

# Yardley Dermatology Associates

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## PERSONAL MEDICAL INFORMATION REQUEST

Yardley Dermatology Associates have my permission to:

	Yes	No
<b>Contact me at home</b>	_____	_____
Leave a detailed voicemail message	_____	_____
Leave a detailed message with household/family member	_____	_____
Name: _____		
_____		
_____		
_____		
<b>Contact me by cell phone # _____</b>	_____	_____
Leave a detailed voicemail message	_____	_____
<b>Contact me at work</b>	_____	_____
Leave a detailed voicemail message	_____	_____
Leave a detailed message with staff member	_____	_____
Name: _____		
_____		
_____		
<b>Discuss my medical history with anyone other than myself</b>	_____	_____
(In addition to those specified by law to carry out treatment, payment and healthcare operations.)		
Name: _____		
_____		
_____		
_____		

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Printed Name